DEPARTMENT	OF HEALTH	AND HUMAN	SERVICES
CENTERS FOR	MEDICARE	& MEDICAID	SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155278				ONSTRUCTION 00	(X3) DATE SURVEY  COMPLETED		
		A. BUILDING B. WING			07/14/2011		
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-BLOOMINGTON			STREET ADDRESS, CITY, STATE, ZIP CODE  155 EAST BURKS DR  BLOOMINGTON, IN47401				
(X4) ID PREFIX TAG	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
F0000	Complaint IN000 Federal/State defallegations are ci Survey Dates: Ju Facility number: Provider number: AIM number: Survey team: Sh Census bed type: SNF/NF: 127 Total: 127 Census payor typ Medicare: 0 Medicaid: 10 Other: 1 Sample: 03 These deficiencies	opes substantiated. Siciencies related to the sted at F-333 and F-514.  Inly 13 and 14, 2011  O00177  155278  100289860  aron Whiteman RN  Oee:  8  Old  18  27  es also reflect state accordance with 410 IAC	F0	0000	Submission of this Respons Plan of Correction is not a leadmission that A deficiency or that this Statement of Deficiency was correctly cite and is also not to be construan admission of fault by the facility, the Executive Direct any employees, agents or o individuals who draft or may discussed in this Response Plan of Correction. In additi preparation and submission this Plan of Correction does constitute an admission or agreement of any kind by the facility of the truth of any facility of the correctness or conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction of any appeal which may be filed so because of the requirements under State and federal law mandate submission of a Pl Correction within ten (10) day the survey as a condition to participate in the Title 18 and 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. Facility respectfor requests a desk review of the Plan of Correction due to the documentation allegations.	egal exists  ed, ued as  or or ther be and ion, of not  ee cts f any e ction colely s that an of ays of d Title  he of fully ne	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155278		(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE SURVEY COMPLETED 07/14/2011		
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-BLOOMINGTON		155 EA	ADDRESS, CITY, STATE, ZIP CODE ST BURKS DR MINGTON, IN47401			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
F0333 SS=D	The facility must e free of any signific Based on record facility failed to a (Resident #A) re in a sample of 3 a medication which resident's clinical which the resident Findings Include Review of Resident record on 07/13/the following:  The inside front or clinical record was alert tag which in allergic to Hydra medication), Qui used to treat irregulation Codeine (pain mode) A hospital discharge 06/10/11, indications.	nsure that residents are ant medication errors. review and interview, the ensure 1 of 3 residents eviewed for drug allergies did not receive in was listed in the 1 record as medication int was allergic to.  :  ent #A's closed clinical 11 at 11:15 p.m. indicated cover of the resident's as observed to have a red adicated the resident was lazine (blood pressure inidine (medication often gular heart rhythms), and	F0333	F 0333 Resident A is not a current resof the facility. The hospital his and physical dated 6/10/11 incurder allergies: Hydralazine (headache) and note that patient currently on Hydralazine with problem. Clonodine (unknow reaction) suspect there is no reaction) suspect there is no reaction) suspect there is no reaction indicate the patient had an to Quinidine or Codiene. The hospital medication discharge indicated allergies: Codiene at Clonodine. The facility Nurse received an order from the phy to administer Clonodine 0.1 m pharmacy was contacted regar the administration of Clonodine dose given to the resident is the lowest possible dose of the medication. The medication is drug of choice with acute hypertension. Regarding administration of the medication the market are to be used cautiously in patients with ren insufficiency.	story dicated  at is out n eaction. cal did allergy list nd  ysician ng. The ding ne. The te ding the the	07/21/2011
	medication).	-		On July 13, 2011, when notifice the surveyor of the transcription		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155278 07/14/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 155 EAST BURKS DR GOLDEN LIVING CENTER-BLOOMINGTON **BLOOMINGTON, IN47401** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE of the allergies; the facility immediately audited all resident A hospital "History and Physical" report, charts to ensure that all allergies dated 06/07/11, listed Clonidine as a were current and the red allergy medication which Resident #A was sticker on the front of the chart, the allergic to. computer generated allergy listings, and the last history and physical all listed the same diagnosis. No other An "Admission" "Clinical Health Status" discrepancies were found. report indicated Resident #A was admitted to the Long Term Care facility from a All Licensed Nurses were in-serviced local hospital on 06/10/11. The on July 21, 2011 regarding the importance of or correctly inputting "Admission" report listed Clonidine as a resident allergies into the computer medication which Resident #A was at the time of admission. The allergic to. Licensed Nurses were also in-serviced to ensure the red allergy A 2010 Nursing Spectrum Drug sticker on the front of the chart matches the computer generated list Handbook indicated Clonidine was to be and history and physical from the used with caution in patients with hospital. diagnosis of Chronic Renal Insufficiency. The Unit managers (Monday-Friday) Resident #A had diagnoses, which and the Weekend RN ( Saturday-Sunday) will audit/review included but were not limited to, End all new admissions to ensure that the Stage Renal Disease, high blood pressure, allergy information was transcribed Tubular Necrosis, Anxiety, and chronic properly into the facility medical obstructive pulmonary disease. record system from the history and physical and discharge medication list received from the hospital as well A nursing note with a "Created Date" of as the allergy sticker located on the 06/21/11 at 7:44 a.m. indicated, "resident chart. (Resident #A) c/o (complained of) not 'feeling well.' Initially her Bp (blood The DNS/ADNS will review the pressure) was 233/126 and O2 (oxygen audits completed by the Unit manager/Weekend RN to ensure all level was 91% on 2L (Liters of oxygen). new admissions were reviewed Called MD and received one time order regarding the allergy information and for clonidine (sic) 0.1 mg (milligram). Bp compile results for review by the QA then went down to 184/94, p (pulse) was

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MI	JLTIPLE CO	NSTRUCTION	(X3) DATE : COMPL		
AND FLAN	OF CORRECTION	155278	A. BUII		00	07/14/2	
		1302.3	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	0171172	
NAME OF	PROVIDER OR SUPPLIE	2			ST BURKS DR		
GOLDEN	N LIVING CENTER-	BLOOMINGTON			INGTON, IN47401		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1 ' ` 1	as) 22. O2 went down to			committee.		
	1	(as needed) albuterol (sic)			The Quality Assurance committ	ee	
	1 `	nent), (sic) No change in			will review the results of the all		
		uration), received order to			admission audits monthly for a		
	send her to the E	, ,			minimum of 3 months and deter	rmine	
	_	tempted (sic) to call			if further audits are needed.		
	I -	mes. left (sic) message					
	with daughter."						
	Documentation	provided by the DON on					
	I .	0 a.m. indicated,					
	1	of Resident #A's decline					
	1	ospital) on 06/21/11					
		ed if she (LPN #1)					
	•	s - said yes - Clonidine					
	1	allergy. States right					
		a.m.) - she would say 5					
	`	went in room and					
	1	o not feeling well - she					
	1 '	gns. B/p (blood pressure)					
		alled (Doctor's name) he					
		Clonidine and send to ER					
	1	Then she went back to					
	1 ^	V/S (vital signs) her					
		2 sat (oxygen saturation)					
	. ,	49%. She (LPN #1) had a					
	1	ner (Resident #A) - She					
	1	out and called 911 and					
	1 ` ′	e then went back and gave					
	1 4 5	A) Clonidine and					
	`	hing treatment). States					
	,	with her (Resident #A) at					
		idine order was written at					
	1	out of EDK at 6:30 AM."					
	1 0.21 11 (a.iii.) -	out of LDIX at 0.30 / MVI.					

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155278	(X2) M A. BUII B. WIN	LDING	NSTRUCTION  00	C	DATE SURVEY COMPLETED //14/2011
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-BLOOMINGTON				STREET A	DDRESS, CITY, STATE, ZIP CO ST BURKS DR IINGTON, IN47401	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	11:00 a.m. indicated LPN #1 she was read the allergies allergy alert tag of chart and Clonid tag.  A copy of a chest indicated, "The with worsening progression since to Department on One Documentation to Department on One Documentation to Department Chartindicated [Reside Chronic Renal Freevidence of respinental status.  A "Coroner Case indicated Reside was "Respiratory death was "Nature of the control of the coroner Case indicated Reside was "Respiratory death was "Nature of the coroner Case indicated Reside was "Natu	tal records on 07/13/11 at the Resident #A arrived the Emergency 6/21/11 at 7:07 a.m.  itled "Emergency rt," dated 06/21/11 ent #A] had diagnoses of ailure, laboratory fratory failure, and altered expert," dated 06/21/11 ent #A's cause of death arrest" and manner of					
	Complaint IN000	_					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	(X3) DATE SURVEY COMPLETED			
ANDILAN	or connection	155278	A. BUILDING 00		07/14/2011	
			B. WING	ADDRESS, CITY, STATE, ZIP CODE	*****	
NAME OF I	PROVIDER OR SUPPLIER		l	ST BURKS DR		
	I LIVING CENTER-			MINGTON, IN47401		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE COMPLETION DATE	
1710	3.1-25(b)(9)	ESC IDENTIFICATION OR MATERIAL OF THE PROPERTY	in id		DITE	
F0514 SS=D	The facility must meach resident in acprofessional stand complete; accurate accessible; and sy.  The clinical record information to identhe resident's asseand services provipreadmission screes tate; and progress Based on record facility failed to (Resident #A) rein a sample of 3, which was accurate resident's alleform designated identify the residentify the residentification of	review and interview, the ensure 1 of 3 residents eviewed for drug allergies had a clinical record ately documented with ergies listed on the facility as the place to look to ent's allergies.	F0514	F0514Resident A is not a curresident of the facility. The hospital history and physical dated 6/10/11 indicated under allergies: Hydralazine (headache) and note that pati is currently on Hydralazine without problem. Clonodine (unknown reaction) suspect the is no reaction. The hospital history and physical did not indicate the patient had an a to Quinidine or Codiene. The hospital medication dischargindicated allergies: Codiene Clonodine. The facility Nurse received an order from the physician to administer Clono 0.1 mg. The pharmacy was contacted regarding the administration of Clonodine.	er ient (here llergy e e list and e odine	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155278		л ріш	DINC	00	COMPLETED	
			A. BUILDING B. WING 07/14/2011			011	
		1	P. 1121		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEI	₹		1	ST BURKS DR		
GOLDEN	I LIVING CENTER-	BLOOMINGTON		1	MINGTON, IN47401		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF		ORRECTION (X5)	
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		ndicated the resident was			dose given to the resident i lowest possible dose of the		
	allergic to Hydra	alazine (blood pressure			medication. The medication		
	medication), Qu	inidine (medication often			drug of choice with acute	1 13 1110	
	used to treat irre	gular heart rhythms), and			hypertension. Regarding		
	Codeine (pain m	nedication)			administration of the medic	ation	
	4	,			to a renal patient. Most all		
	A hospital disch	arge medication list, dated			medications on the market		
	_	ted the resident was also			be used cautiously in patie		
	l '				with renal insufficiency. O 13, 2011, when notified by	-	
	~	dine (blood pressure			surveyor of the transcription		
	medication).				of the allergies; the facility		
					immediately audited all res	dent	
	A hospital "Histo	ory and Physical" report,			charts to ensure that all all	ergies	
	dated 06/07/11,	listed Clonidine as a			were current and the red al		
	medication whic	h Resident #A was			sticker on the front of the cl		
	allergic to.				the computer generated all		
					listings, and the last history physical all listed the same	ano	
	An "Admission"	"Clinical Health Status"			diagnosis. No other discrep	ancies	
		Resident #A was admitted			were found. All Licensed I		
	1 ^				were in-serviced on July 21	, 2011	
		n Care facility from a			regarding the importance o	f or	
	local hospital on				correctly inputting resident		
	_	oort listed Clonidine as a			allergies into the computer		
	medication which	th Resident #A was			time of admission. The Lice Nurses were also in-service		
	allergic to.				ensure the red allergy stick		
					the front of the chart match		
	A 2010 Nursing	Spectrum Drug			computer generated list an		
		ated Clonidine was to be			history and physical from the		
		n in patients with			hospital. The Unit manage	rs	
		onic Renal Insufficiency.			(Monday-Friday) and the	day.:\	
		one renarmounery.			Weekend RN ( Saturday-S will audit/review all new	unday)	
	Dagidant # A 1 4	diagnagas which			admissions to ensure that t	he	
		diagnoses, which			allergy information was		
		re not limited to, End			transcribed properly into the	e	
	~	ease, high blood pressure,			facility medical record syste		
	Tubular Necrosi	s, Anxiety, and chronic			from the history and physic		
	obstructive pulm	nonary disease.			discharge medication list re	ceived	

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING	00	COMPL		
		155278	B. WING	i		07/14/2	011	
NAME OF I	PROVIDER OR SUPPLIER		.		DDRESS, CITY, STATE, ZIP CODE			
					ST BURKS DR			
GOLDEN	I LIVING CENTER-I	BLOOMINGTON		BLOOM	IINGTON, IN47401			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	,		DATE	
TAG	A nursing note w 06/21/11 at 7:44 (Resident #A) c/c 'feeling well.' In pressure) was 23 level was 91% of Called MD and r for clonidine (sic then went down 96, r (respiration 49. Gave PRN (c (breathing treatm sats (oxygen satus send her to the E Department). att family several tir with daughter."  Documentation p 07/14/11 at 11:40 "Investigation" (c and transfer to he indicated, "Asket checked allergies was not a listed a before 6 A (6:00 minutes till she w (Resident #A) c/c took her vital sig was elevated. Care	provided by the DON on a.m. indicated, of Resident #A's decline ospital) on 06/21/11 d if she (LPN #1) s - said yes - Clonidine allergy. States right a.m.) - she would say 5		TAG	from the hospital as well as allergy sticker located on the chart. The DNS/ADNS will represent the audits completed by the manager/Weekend RN to error all new admissions were reviewed regarding the allerginformation and compile rest for review by the QA commit The Quality Assurance commit The Quality Assurance commit review the results of the allergy admission audits more for a minimum of 3 months and determine if further audits are needed.	e eview Unit naure  gy ults tee. mittee  nthly	DATE	
		hen she went back to						
	•	/S (vital signs) her						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155278			(X2) MUI A. BUILD B. WING		NSTRUCTION  00	(X3) DATE ( COMPL <b>07/14/2</b>	ETED
NAME OF F	PROVIDER OR SUPPLIER		I .		DDRESS, CITY, STATE, ZIP CODE	!	
GOLDEN	I LIVING CENTER-I	BLOOMINGTON			ST BURKS DR INGTON, IN47401		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	,	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
	(Resident A's) O	2 sat (oxygen saturation)					
		49%. She (LPN #1) had a					
	1	er (Resident #A) - She					
	l ` ′	ut and called 911 and					
	her (Resident #A	then went back and gave					
	`	ning treatment). States					
	`	vith her (Resident #A) at					
		dine order was written at					
		out of EDK at 6:30 AM."					
	, , ,						
	Interview of the	DON on 07/14/11 at					
		ated upon questioning					
		told that the LPN had					
		to the physician from the					
	""	on the front cover of the					
		ine was not included on					
	the alert tag as be	eing an allergic					
	medication						
	   This Federal/Stat	te deficiency relates to					
	Complaint IN000	-					
	•						
	3.1-50(a)(1)						